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Brief Report

Individual Change After Genocide in Bosnian Survivors of "Ethnic Cleansing": Assessing Personality Dysfunction

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The authors used the SCID-DES (disorders of extreme stress) instrument to assess for personality change in Bosnian survivors of "ethnic cleansing." Twenty four refugees underwent systematic, trauma-focused, research assessments, including the SCID-DES interview. Overall, this group of Bosnian survivors had been severely traumatized as a result of the Serbian nationalists' genocide. However, no subject met diagnostic criteria for DES. The SCID-DES yields far lower rates of trauma-related personality change in Bosnian survivors of genocide than in adult survivors of prolonged early life traumas. Therefore, the DES construct may have better application to prolonged, interpersonal, early life traumas than to the prolonged, communal traumas of genocide.

KEY WORDS: disorders of extreme stress; genocide; personality; trauma.

Recent work in the field of traumatic stress has convinced many professionals of the inadequacy of the current diagnostic classification of trauma-related psychopathology. Many clinicians, researchers, and theorists have asserted that trauma can lead to changes in personality functioning—and have expressed frustration that there is, at present, no means for adequately representing trauma-related personality changes within in our nosology. In response, there have been efforts to define new diagnostic categories, such as the "enduring personality change after catastrophic ex-

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perience" proposed for ICD-10 (World Health Organization, 1990), and the "disorders of extreme stress not otherwise specified" (DESNOS) that was proposed for DSM-IV (Herman, 1992, 1993). Although DES was not accepted into DSM-IV, the construct remains worthy of investigation because: (1) it represents a current, serious attempt to construe a broader posttraumatic syndrome; (2) it is a construct widely used by mental health professionals who specialize in the evaluation and treatment of trauma-related syndromes; and (3) there are, as yet, few published reports of its use in clinical settings (Pelcovitz et al., 1997; Zlotnick et al., 1996).

DES encompasses a range of trauma-related problems not included in the posttraumatic stress disorder (PTSD) construct—such as: (1) altered affect or impulse regulation; (2) altered attention or consciousness; (3) altered self-perception; (4) altered perception of the perpetrator; (5) altered relations with others; (6) somatization; and (7) altered systems of meaning (Herman, 1992, 1993). DES, along with its ICD-10 counterpart, rests on the theory that persistent changes in personality functioning subsequent to traumatic exposure are attributable not to pre-existing personality or character disturbances, but to the traumatic exposure itself. Personality change is believed to result from traumatic experiences that are especially intensive, prolonged, and repeated. Indeed, DES has most often been used to describe the adult sequelae of childhood incest, abuse, and neglect.

Refugees who have endured genocide, torture, atrocities, and forced resettlement can be said to have suffered prolonged, multiple, and repeated traumatization (Weine et al., 1995). Moreover, Herman's (1992) original descriptions of DES were sufficiently broad to encompass traumatized refugees, as well as other survivors of state-sponsored violence—such as concentration camp detainees and prisoners of war. This was based, in part, on prior research which found evidence for personality change in traumatized refugees (Dorshav, 1978; Krystal & Niederland, 1968). In addition, Westermeyer (1988) has proposed the "chronic acculturation syndrome" to describe the outcome of refugee trauma—however, this concept has not been widely used.

Our report concerns the traumatic exposure and SCID-DES assessments of a group of 24 adult and adolescent Bosnian refugees of "ethnic cleansing," seen in evaluation approximately 1 year after resettlement in the United States—and 2 to 3 years after the traumatic experiences. We aimed to describe: (1) the extent of traumatic exposure associated with "ethnic cleansing;" (2) the extent to which the outcome of this exposure is captured by the DES construct; and (3) the potential uses and limitations of measures of personality dysfunction in describing posttraumatic change in the survivors of "ethnic cleansing."

Method

Subjects

Subjects consisted of a subgroup of 31 Bosnian refugees originally evaluated soon after their resettlement in Connecticut. [Baseline evaluation data on 20 of the first 22 subjects are presented in a previous report (Weine et al., 1995).] Of these 31 individuals, 24 agreed to participate in follow-up interviews that included the SCID-DES, approximately 1 year later. This group consisted of 12 men and 12 women. Ages ranged from 13 to 59 (M = 34) years. All had previously lived in Bosnia and were ethnic Muslims. All gave written, informed consent to participate in this project.

SCID-DES Instrument

The SCID-DES instrument was specifically designed for the purpose of eliciting the symptoms of DES (van der Kolk, unpublished manuscript). It has shown high interrater reliability (with kappas for current and lifetime DES ranging from .88 to 1.0), high internal cohesion for the six individual symptom categories (with Cronbach alpha coefficients ranging from .76 to .90 for six of seven categories) and high internal cohesion for the overall measure (α = .96). The category "altered perception of perpetrator" was dropped as a requirement for the diagnosis of DES because its alpha coefficient was lower than .70. Subjects are considered to have the diagnosis of DES if they have a requisite number of symptoms in each of the six remaining symptom categories (Pelcovitz et al., 1997).

Procedures

As indicated above, interviews for this study were part of the follow-up phase of a study begun approximately 1 year previously. The methods for that study—which consisted of a baseline evaluation and which provided subjects with the opportunity to give testimony about their traumatic experiences—are described in detail elsewhere (Weine et al., 1995). As in the initial assessments, interviews for the follow-up study were conducted at the Traumatic Stress Clinic of the Yale Psychiatric Institute—or, in some cases, at the homes of the refugees. Interviews were performed by one or two mental health professionals from an interdisciplinary team, accompanied by a lay interpreter. Interviewers were trained clinical research staff who were familiar with the diagnostic constructs of PTSD and DESNOS, with the Bosnian culture, and with the use of structured interviews. All participated in training sessions in which they were familiarized with these

specific research instruments and with selected background literature. The research instruments were translated into Croatian by a team of interpreters and clinicians; back translations were used to check accuracy.

Assessment for PTSD diagnosis was performed using a translated version of the PTSD Symptoms Scale (Foa, Riggs, Dancu, & Rothbaum, 1993). This scale consists of 17 items, each rated on a 4-point scale, that correspond to the DSM-III-R criteria for PTSD; it assesses the number and severity of PTSD symptoms and symptom clusters. The PTSD Symptoms Scale has been shown to have a high test-retest reliability, good concurrent validity, high interrater agreement, and excellent convergent validity with the SCID. To meet diagnostic criteria for PTSD, a subject must have a requisite number of symptoms in each of the three symptom clusters.

As part of their initial assessments approximately one year previously, all subjects had been interviewed with the Communal Traumatic Experiences Inventory (CTEI; Weine et al., 1995). This instrument had been developed for the study of Bosnian refugees, based upon other screening instruments used for refugees of genocidal trauma (Mollica & Caspi-Yavin, 1991; Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987; Norris, 1990). This 36-item, clinician-administered questionnaire yields a profile of traumatic events experienced by survivors of communal trauma. It screens for 30 different kinds of traumatic events that have been commonly associated with "ethnic cleansing." A CTEI score was generated for each subject, reflecting the number of different types of traumatic experiences endured by that individual.

Results

Traumatic Exposure and PTSD Diagnosis

Overall, this group of Bosnian survivors reported having been severely traumatized as a result of the Serbian nationalists' genocide. CTEI scores indicated that individuals were exposed to an average of 16 types of traumatic experiences (range 7 to 24). At the time of the follow-up assessment, 10 (42%) subjects met criteria for PTSD.

DES Diagnosis and Symptoms

No subject met diagnostic criteria for DES—that is, no subject fulfilled criteria for all six required symptom categories. The number of categories fulfilled ranged from 0 to 5. Percentages of subjects who met specific DES symptom category criteria is as follows: altered system of meaning—33%;

somatization—29%; altered self-perception—25%; altered relationships with others—25%; altered regulation of affect/impulse—17%; altered attention/ consciousness—17%; altered perception of perpetrator—0%. Subjects with PTSD met more DES categories than those without PTSD (means of 2.2 and 1.0, respectively).

Discussion

We found that, despite a high rate of exposure to prolonged traumas and a relatively high rate of PTSD diagnosis, none of our subjects met criteria for DES. The SCID-DES yielded a far lower rate of trauma-related personality change in Bosnian survivors of genocide than has been suggested for adult survivors of prolonged early life traumas (Herman, 1992; Herman, 1993). This is the first report indicating that the DES construct may have better application to prolonged, interpersonal, early life traumas (such as childhood physical and sexual abuse) than to the prolonged, communal traumas of genocide. Our preliminary findings run contrary to the original concept of DES—the proponents of which hypothesized that any traumatic experiences that are prolonged, multiple, repeated, and occur in an environment of coercive control would likely yield a picture of DES-NOS, rather than simply of PTSD.

Because the SCID-DES instrument did document posttraumatic changes in a number of realms of life experience, we should take seriously the invitation to formulate a posttraumatic syndrome that is broader than PTSD. Though preliminary, our results suggest that a paradigm of posttraumatic personality dysfunction may not offer the best model for understanding the psychiatric outcomes of "ethnic cleansing." The assumption that prolonged trauma results in personality change seems most compelling for children and younger adolescents in whom trauma may occur during key developmental periods in the laying down of personality (van der Kolk, 1987).

In our subjects, this assumption may be less justified. Here, any potential observations of personality change are potentially complicated by multiple, trauma-related changes in other experiential realms. These changes—such as in the narrative constructions of historical realities (Weine & Laub, 1995), family communication (Weine, Vojvoda, Hartman, & Hyman, in press), ethnic identity (Birman, 1994), personal identity (Erikson, 1980; Lifton, 1993) and life structure (Levinson, 1978)—represent the broader realities of the stark effects of genocide. Efforts to extend the phenomonological focus beyond PTSD are needed. However, emphasizing personality change in survivors of state-sponsored violence—without evidence to support such a formulation—runs the risk of misconstruing the profound

social, cultural, existential, and moral dilemmas embodied by these individuals as "neurosis." Alternatively, mental health professionals seeking a broader understanding of the psychiatric sequelae of state-sponsored violence may supplement the psychiatric construct of traumatic stress with other paradigms derived from the approaches of human rights (Agger & Jensen, 1996), community psychology (Watts, 1992), creative arts (Langer, 1995), and interpretive social science (Lifton, 1979).

Our study does have several limitations. First, the sample size is small, limiting generalizability of our results to broader populations. Second, nearly a quarter of our original sample chose not to participate in this phase of the study. We cannot rule out the possibility that the nonparticipant group included individuals who would have met criteria for DESNOS. Third, our follow-up interval may have been too short to allow full manifestation of the syndrome under investigation. Fourth, although our subjects received minimal treatment during the follow-up interval, the baseline evaluation did provide an opportunity to give testimony about traumatic experiences. As this testimony was intended—in part—to be therapeutic, we must acknowledge that this intervention may have reduced subsequent psychopathology, and confounded our results. Fifth, our lack of reliability data for our research setting may in itself suggest an explanation for our negative findings. Finally, the ethnocultural relevance of the research instruments remains an open question. Nonetheless, our preliminary study does point to the need for further research. Longitudinal studies of ethnoculturally-sensitive design, and using larger samples of survivors of state-sponsored violence, will more conclusively address the questions raised here.

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